COMPREHENSIVE FOOT & ANKLE CARE
Anne McNamara, D.P.M.
Melissa Winter, D.P.M.
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Informed Consent for Insurance Billing and Patient Financial Responsibility

1. I give permission to the Podiatrists of Comprehensive Foot & Ankle Care, and any appointed assistants, to administer treatment and to perform such procedures as may be deemed necessary in the treatment of my foot and/or ankle disorder.

2. I assign to the above-named Podiatrists all benefits provided by my insurance company policy or policies (including Medicare) for such treatment, and authorize the release of any medical information necessary to process my insurance claim.

3. I understand that I am responsible for paying all co-payments, deductibles, and non-covered services, and that payment is to be made in full at the time of service.

4. I further understand that if I am found in default of payment, I am responsible for all costs associated with monetary collection including but not limited to: balance due, attorney fees, and a collection agency fee of 30% of the balance due.

5. Missed appointments or appointment cancelled without a minimum of 24 hours notice will be charged a $25 fee.

6. I have been offered this office's Notice of Privacy Practices, which explains how medical information about me may be used and disclosed. I understand that I am entitled to receive a copy of the Notice of Privacy Practices at my request.